

SCHEDULE OF BENEFITS PLAN 501 B

This chart shows what the Plan pays. All benefits are subject to the deductible except where noted otherwise.
See Rules and Regulations in this booklet for more information.

| Benefit Description | Explanation and Limitations | PPO Providers (In-Network) | Non-PPO Providers (Out of Network) |
|--|--|-------------------------------|---------------------------------------|
| Accident – Supplemental | <ul style="list-style-type: none"> • No deductible • 100% of 1st \$300.00 per accident if treated within 30 days of accident and charge is incurred within 6 months of the accident • After the 1st \$300.00 benefits payable @ 80% or 70% - subject to deductible. | 80% | 70% |
| Acupuncture | <ul style="list-style-type: none"> • Payable when administered by a Physician • subject to deductible | 80% | 70% |
| Ambulance | <ul style="list-style-type: none"> • Air – Per Trip • Surface – Maximum of \$600.00 per trip • subject to deductible | 80% | 70% |
| Anesthesia | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Assistant Surgeons | <ul style="list-style-type: none"> • Maximum of 20% of surgeon’s benefit • subject to deductible | 80% | 70% |
| Blood transfusions and blood products | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| COB -Carve Out Method | <ul style="list-style-type: none"> • Applies to Medical claims only • subject to deductible | N/A | N/A |
| Convalescent Care Facility | <ul style="list-style-type: none"> • Maximum allowable expense –\$80 per day. Not for custodial or long-term care; maximum of 60 days per Calendar Year. Must be preceded by hospitalization in a covered facility. • Max 60 days per calendar year/subject to deductible | 80% | 80% |
| <ul style="list-style-type: none"> • Not for custodial care • Pre-certification required | | | |
| Chemotherapy | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Chiropractic Care | <ul style="list-style-type: none"> • Maximum allowance: \$40 per visit • Max 25 visits per year/subject to deductible | 50% | 50% |
| <ul style="list-style-type: none"> • Manipulations and x-rays only | | | |
| Death Benefits | <ul style="list-style-type: none"> • Employee \$5,000.00 • Dependent – \$1,000.00 | N/A | N/A |
| Deductible | <ul style="list-style-type: none"> • \$250.00 per person • \$600.00 per family | N/A | N/A |
| <ul style="list-style-type: none"> • Per calendar year | | | |
| Diagnostic Outpatient | <ul style="list-style-type: none"> • 100% of the 1st \$200.00 • After the 1st \$200.00 benefits payable @ 80% or 70% - subject to deductible. | 80% | 70% |
| <ul style="list-style-type: none"> • X-ray and Laboratory | | | |
| Diabetic Supplies | <ul style="list-style-type: none"> • Diabetic Supply Program through Nations Health– mail order, No co-pay, no deductible; paid at 100% - call 1-800-354-1653 | 80% | 70% |
| (Effective 1/1/2010) | | | |
| Dialysis | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |

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|---|---|-------------------------------|---------------------------------------|
| Dietary/Nutritional/Herbal | <ul style="list-style-type: none"> • Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered. • No over-the-counter drugs are reimbursed. | N/A | N/A |
| Durable Medical Equipment (DME) | <ul style="list-style-type: none"> • Charges for rental of wheelchair, special Hospital Bed, iron lung, crutches, and other reasonable mechanical therapeutic and durable medical equipment, but not to exceed the purchase of such equipment. • subject to deductible | 80% | 70% |
| Emergency Room (ER) | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Experimental Treatment | Vax-D, IDD and any other experimental treatment is not covered. | 0% | 0% |
| Hearing Benefit | <ul style="list-style-type: none"> • No Benefits Available | N/A | N/A |
| Home Health Care | <ul style="list-style-type: none"> • Maximum of 60 visits per year • subject to deductible | 80% | 70% |
| Hospice Care | <ul style="list-style-type: none"> • Treatment for terminal illnesses for individuals whose life expectancy is six months or less • subject to deductible | 80% | 70% |
| Hospital (Inpatient) (Pre-certification) | <ul style="list-style-type: none"> • Room and Board • Intensive Care Unit • subject to deductible | 80% | 70% |
| Hospital – Other Charges | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Infertility | <ul style="list-style-type: none"> • Lifetime maximum \$10,000 for covered expenses • subject to deductible | 80% | 70% |
| Laboratory Services | <ul style="list-style-type: none"> • Subject to deductible after 1st \$200 | 80% | 70% |
| Lifetime Max | <ul style="list-style-type: none"> • \$350,000.00 | N/A | N/A |
| Mammogram Benefit <ul style="list-style-type: none"> • No deductible (Effective 01/01/08) | <ul style="list-style-type: none"> • Women Ages 30 – 39: One single baseline mammogram during that ten year period, payable up to \$300.00. • Women age 40 & over: One mammogram every calendar year payable up to \$300.00. | 80% | 70% |
| Maternity For employee or legal spouse only | <ul style="list-style-type: none"> • Maternity charges are paid @ global rate at time of delivery • Lab charges, ultrasound or non-fetal stress test not included in global charges • Healthy Maternity Program: Initial OB Care – Call the Fund Office to enroll | 80% | 70% |
| Nutritional/ Dietary | <ul style="list-style-type: none"> • Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered. | N/A | N/A |

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|--|--|--|---|
| Outpatient Expenses | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Outpatient Surgical Facility | <ul style="list-style-type: none"> • No pre-authorization required for in-network facilities • In a hospital-based or Free standing surgery center/ subject to deductible | 80% | 70% |
| Orthopedic Equipment Orthotics & Braces (Must have RX) | <ul style="list-style-type: none"> • Charges for prescribed orthopedic shoes and other supportive appliance • Includes replacement once every 12 months • Includes replacement once every 6 months for 19 years or under • subject to deductible | 80% | 70% |
| Physician And Health Care Practitioner Office Visit Services | <ul style="list-style-type: none"> • One co-pay per office visit • Charges for other services provided at the physician's office subject to deductible then payable at 80% or 70% | 100% less the \$15 co-pay | 70% Deductible Applies |
| Physical Exam • No deductible | <ul style="list-style-type: none"> • Paid at 100% up to \$250 maximum per calendar year • Includes routine evaluations, lab charges, x-rays • No co-pay | Up to max benefit of \$250.00 | Up to max benefit of \$250.00 |
| Physical, Occupational & Osteopathic Manipulative Therapy | <ul style="list-style-type: none"> • Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist • Prescription for frequency and duration required by a Physician (M.D. or D.O.) • 16 visits per calendar year combined • Does not include maintenance or Industrial care • subject to deductible | 80% | 70% |
| Prescription Drugs (Outpatient) | <p style="text-align: center;">Informed RX 1-800-880-1188</p> <ul style="list-style-type: none"> • Generic • Brand Name (no generic equivalent) • Brand name (with generic equivalent) • Certain drugs will be covered by the plan only after less costly alternatives have been explored. In furtherance of such a program, the plan may be provide coverage of non prescription medications that would otherwise not be covered by the plan | In-Network Retail Pharmacy • \$10 co-pay • \$30 co-pay • \$45 co-pay | Out of Network Pharmacy 70% |
| Pre-Certification/Authorization | Also required for SNF admits & Transplants – Call Medical Management, (602) 249-3582 option 6 | | |
| Pre-Existing | • \$1,000.00 maximum benefit | 80% | 70% |

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|--|---|-------------------------------|---------------------------------------|
| Preventive (Wellness) Services | <ul style="list-style-type: none"> • Immunization through age 18 and other treatment • subject to deductible | 80% | 70% |
| Prosthetic Appliances | <ul style="list-style-type: none"> • Items replacing a missing body part, such as an artificial limb • Prescription of medical necessity required • subject to deductible | 80% | 70% |
| Lasik (RK) | <ul style="list-style-type: none"> • No benefit | N/A | N/A |
| Radiology and Nuclear Medicine Services | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |
| Smoking Cessation | <ul style="list-style-type: none"> • No benefit | N/A | N/A |
| Speech Therapy | <ul style="list-style-type: none"> • Payable when rendered by a Licensed Speech Pathologist • Covered for patients who have had an injury or surgery affecting speech for 90 days following the event. • Speech therapy benefits are available for dependent children under age 17 for diagnoses listed in the Plan Booklet (pre-certification required). • Up to 32 visits per calendar year • Prescription for frequency and duration required by a Physician • Subject to deductible. | 80% | 70% |
| Stop Loss | <ul style="list-style-type: none"> • \$20,000.00 • Benefits payable @ 100% of allowable charges once stop loss has been met, unless otherwise noted. • Per calendar year | N/A | N/A |
| Surgeons | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |

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|---|---|-------------------------------|---------------------------------------|
| TMJ (temporomandibular joint dysfunction) | <ul style="list-style-type: none"> • \$3,000.00 lifetime maximum benefit (effective 3/1/06) Prior to 3/1/06 was \$2,000.00 • Hospital In-patient facility charges not subject to the TMJ lifetime max. • subject to deductible | 80% | 70% |
| Well Baby Care (Co-Pay applies to Office Visit) | <ul style="list-style-type: none"> • Immunization through age 18 and other treatment • subject to deductible | 80% | 70% |
| Working Spouse Reduction | <ul style="list-style-type: none"> • Benefit rate payable for spouse's charges when other insurance is offered through their employer but is declined | 40% | 40% |
| All Other Covered Charges | <ul style="list-style-type: none"> • subject to deductible | 80% | 70% |

In Network



Secondary Wrap Network



SCHEDULE OF BEHAVIORAL HEALTH BENEFITS PLAN 501 B

See Rules and Regulations in this booklet for more information.

HMC/APS Healthcare 800-464-7101

| Benefits | Coinsurance Payable by the Plan | |
|-----------------------------|---|---|
| | Precertified Providers (In-Network) | Non-Precertified Providers (Out of Network) |
| Deductible | <ul style="list-style-type: none"> • No Deductible | <p style="text-align: center;">\$250.00 per person \$600.00 per family</p> <ul style="list-style-type: none"> • Deductible applies in conjunction with individual and family medical deductible |
| Psychiatric | <ul style="list-style-type: none"> • 45 days per calendar year 120 per lifetime • Hospital – 100% of EMAP approved treatment • Professional Fees- 100% of EMAP approved treatment | <ul style="list-style-type: none"> • 45 days per calendar year 120 per lifetime • Hospital - 65% of EMAP negotiated rates • Professional Fees - 65% of EMAP approved treatment |
| Alcohol/ Drug | <ul style="list-style-type: none"> • 2 admits per lifetime • 28 day per admission • Detox – 2 per lifetime 7 days per admission • Treatment must be completed for benefits to be paid. • Hospital – 100% of EMAP approved treatment for first treatment 95% for second treatment • Professional Fees – 100% of EMAP approved treatment for first treatment 95% for second treatment | <ul style="list-style-type: none"> • 2 admits per lifetime • 28 day per admission • Detox – 2 per lifetime 7 days per admission • Treatment must be completed for benefits to be paid. • Hospital – 65% of EMAP negotiated rates • Professional fees – 65% of EMAP negotiated rates |
| Outpatient Treatment | <ul style="list-style-type: none"> • 50 visits per calendar year including MD's, Ph.D's and licensed social workers • No deductible • First 8 visits no co-pay applies • After 8 visits co-pay applies: \$5 co-pay for Master level and Psychologist \$10 co-pay for MD's | <ul style="list-style-type: none"> • Deductible applies • 65% of EMAP negotiated rates |

SCHEDULE OF INDEMNITY DENTAL PLAN BENEFITS PLAN 501 B

Note: Dental services may be obtained from any licensed dental care provider.

| | |
|--|--|
| Deductible | None |
| Annual Dental Plan Maximum | \$750.00 |
| Surgical Treatment <ul style="list-style-type: none"> • Excision of bony impacted teeth • Root canals with apicoectomy • Osseous surgery with graft or gingivectomy | 50% of Allowable expenses |
| Diagnostic & Preventative <ul style="list-style-type: none"> • Exams (2 per calendar year) • Fluoride Treatment 2 per calendar year) • Prophylaxis (2 per calendar year) • Bitewing X-Rays (2 per calendar year) • Full Mouth X-Rays (1 per calendar year) • Sealants • Space Maintainers | 80% of Allowable expenses |
| Restorative & Surgical Treatment <ul style="list-style-type: none"> • Fillings • Extractions • Oral Surgery • Anesthesia • Periodontal Services • Endodontics | 50% of Allowable expenses |
| Prosthetic Treatment <ul style="list-style-type: none"> • Crowns • Bridges • Dentures (Replacements limited to every 5 years) | 50% of Allowable expenses |
| Orthodontic | No Benefits |
| Not Covered | <ul style="list-style-type: none"> • Tooth Implants and related services • Cosmetic procedures • Replacement for lost, misplaced or stolen bridge or dentures |
| Notes | <ul style="list-style-type: none"> • Claims may be subject to an independent dental review. • Supporting x-rays and/or notes may be required or requested. |
| Waiting Period | 6 month waiting period |

SCHEDULE OF VISION PLAN BENEFITS PLAN 501 B

Payable vision services must be obtained from the in-network Vision Care Providers. Contact the Vision Plan (as noted on the Quick Reference Chart) for the list of in-network vision providers.

Waiting Period: 6 months

| Vision Services Call VSP 1-800-877-7195 In- Network | Non- Network | |
|--|---|--|
| Vision Exam <ul style="list-style-type: none"> • Covered in Full • Every 12 months | \$35.00 | Benefit allowances same as In-network. Bills must be submitted to VSP for reimbursement. Services rendered in Mexico paid by SSA |
| Lenses: <ul style="list-style-type: none"> • Covered in full • Single vision, lined bifocal and lined trifocal lenses | Single \$42 Bi-Focal \$65 Tri-Focal \$82 Lenticular \$82 | |
| Contact Lenses <ul style="list-style-type: none"> • If Medically Necessary • Every 12 months • Your \$117.00 allowance applies to cost and the fitting and evaluation exam. | \$190 | |
| Contact Lenses <ul style="list-style-type: none"> • Cosmetic | \$82 | |
| Frame Allowance <ul style="list-style-type: none"> • Every 12 months • Covered up to \$115.00 Plus 20% off any out of pocket cost. | \$40 | |

SCHEDULE OF DISABILITY INCOME BENEFITS PLAN 501 B

See Rules and Regulations in this booklet for more information (Article 6)

| | |
|--|---|
| Accident | • Payable from the 1 st day |
| Illness | • Payable from the 8 th day |
| Maximum Benefit period | • 13 weeks after the one-week waiting period. Contact 1-800-474-3485 option 8 for forms and questions. |
| Benefit Percentage | 70% of the base weekly earnings, not to exceed the maximum benefit. |
| Benefit Calculation: | |
| Gross weekly maximum benefit | \$162.43 |
| Less FICA tax | <u>- 12.43</u> |
| Net weekly maximum benefit | \$150.00 |
| (Federal and State Income Tax Not Withheld) | |
| | |

SSA MEXICO PPO NETWORK

Optional Benefit Program For Medical, Dental and Vision Expenses

The following benefits are covered at 100% of Allowed Amount, After your co-pay

If discharge planning is needed in the USA after a procedure, contact Medical Management Department for Care Coordination

| | |
|----------------------|---|
| \$5.00 co-pay | • Medical /Hospital Expenses |
| \$5.00 co-pay | • Dental / Vision Expenses |
| \$3.00 co-pay | • For each prescription • Medications that do not require an RX in the United States, will not be covered |

Benefits will be paid to the appropriate provider through the SSA network

ONLY THE SERVICES WHICH ARE RENDERED BY THESE PROVIDERS WILL BE COVERED.

Contact the Fund Office with questions regarding your benefits